STATE OF MICHIGAN
CIRCUIT COURT FOR THE 30TH JUDICIAL CIRCUIT
INGHAM COUNTY

In the Matter of:
LINDA A. WATTERS, COMMISSIONER,
OFFICE OF FINANCIAL AND INSURANCE SERVICES
FOR THE STATE OF MICHIGAN

Petitioner,

-v-

File No. 03-1127-CR

THE WELLNESS PLAN,
a Michigan health maintenance organization

Hon. William E. Collette

Respondent.
_____/

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BRIEF REGARDING PRIORITY OF PROVIDER CLAIMS
FOR PURPOSES OF THE WELLNESS PLAN REHABILITATION

The hospitals and health systems identified below (hereinafter, the "Wellness Plan Providers," by and through their attorneys, Nuyen, Tomtishen and Aoun, P.C., and

pursuant to this Court's February 28, 2005 Order Setting Briefing Schedule and Establishing Notice Procedure With Respect to the Issue of The Priority of Provider Claims, hereby submit their Brief Regarding Priority of Provider Claims for Purposes of The Wellness Plan Rehabilitation.

I. Identification of Wellness Plan Providers

This Brief Regarding Priority of Provider Claims for Purposes of The Wellness Plan Rehabilitation is submitted on behalf of the following hospitals and health systems, their employed physicians and their affiliated entities, as creditors of The Wellness Plan:

- Genesys Regional Medical Center
- Genesys Health Park (Grand Blanc)
- Genesys East Flint Campus (Burton)
- Genesys West Flint Campus (Flint)
- Hackley Hospital (Muskegon)
- Hackley LakeShore Hospital (Shelby)
- Henry Ford Health System
- Henry Ford Health System, d/b/a Henry Ford Hospital (Detroit)
- Henry Ford Bi-County Hospital (Warren)
- Henry Ford Wyandotte Hospital (Wyandotte)
- Detroit Osteopathic Hospital Corp., d/b/a Riverside Osteopathic Hospital
- Oakwood Healthcare System
- Oakwood Hospital & Medical Center (Dearborn)
- Oakwood Annapolis Hospital (Wayne)
- Oakwood Heritage Hospital (Taylor)
- Oakwood Southshore Medical Center (Trenton)
- POH Medical Center (Pontiac)
- St. John Health
- St. John Hospital and Medical Center (Detroit)
- St. John Northshore Hospital (Harrison Township)
- St. John River District Hospital (East China Township)
- St. John Oakland Hospital (Madison Heights)
- St. John Northeast Community Hospital (Detroit)
- St. John Macomb Hospital (Warren)
- St. John Riverview Hospital (Detroit)
- Brighton Hospital (Brighton)
- Providence Hospital and Medical Center (Southfield)
- Spectrum Health
- Spectrum Health – Blodgett Campus (Grand Rapids)

- Spectrum Health – Butterworth Campus (Grand Rapids)
- Spectrum Health – DeVos Children's Hospital (Grand Rapids)
- Spectrum Health – Kelsey Campus (Lakeview)
- Spectrum Health – Kent Community Campus (Grand Rapids)
- Spectrum Health – Reed City Campus (Reed City)
- Spectrum Health – United Campus (Greenville)
- William Beaumont Hospital (Royal Oak)
- William Beaumont Hospital (Troy)

Each of the foregoing hospitals and health systems is a nonprofit corporation, tax-exempt under Internal Revenue Code Section 501(c)(3). Collectively, the foregoing hospitals and health systems have rendered tens of millions of dollars of covered health care services to individuals enrolled in The Wellness Plan's health care programs, for which they have filed claims and not received payment.

II. Background

The Wellness Plan is a health maintenance organization ("HMO"). The vast majority of The Wellness Plan's HMO membership consisted of Medicaid beneficiaries enrolled with The Wellness Plan pursuant to a qualified health plan contract between it and the State of Michigan. As a Medicaid HMO, The Wellness Plan was subject not only to the HMO Act, MCL §§ 500.3501 *et seq.*, but also the Social Welfare Act, MCL §§ 400.1 *et seq.* and federal law and regulation governing the activities of Medicaid managed care organizations, including the federal regulations at 42 CFR Part 438.

III. Priority of Provider Claims

A. Provider Claims

Section 8142 of the Insurance Code, MCL § 500.8142, sets forth the priority of distribution of claims from an HMO's estate. The claims of health care providers, including the Wellness Plan Providers, are Class 2 claims for purposes of Section

500.8142. Section 500.8142(1)(b) defines Class 2 claims as "[A]ll claims under policies for losses incurred, including third party claims . . . ."

As explained in more detail below, The Wellness Plan providers are seeking payment for health care services which are explicitly covered under the health maintenance contracts issued by The Wellness Plan to its enrollees. These health maintenance contracts are the "policies" issued by an HMO such as The Wellness Plan. See MCL § 500.3501(e). Copies of the form of health maintenance contracts issued by The Wellness Plan to its enrollees are attached hereto as Exhibits A and B.[1] It seems too obvious for words that the medical expense payments made by The Wellness Plan to a provider for health care services explicitly covered under The Wellness Plan's health maintenance contracts constitute "losses incurred" for purposes of Section 8142.

1. The Wellness Plan Providers are Within The Class of Claimants Contemplated Under Class 2

There is nothing in the claims priority statute, Section 500.8142 (or elsewhere in Chapter 81 for that matter), prohibiting health care providers, such as The Wellness Plan Providers, from being Class 2 claimants. As noted, Class 2 claims include "[A]ll claims under policies for losses incurred, including third party claims . . . ." MCL § 500.8142(1)(b). Accordingly, the scope of Class 2 claims is not limited to a specific category of claimant, such as insureds or, in the case of an HMO, its enrollees.[2] Indeed, Class 2 claims specifically include "third party claims." This is not surprising since, as

[1] Exhibit A is a copy of The Wellness Plan's Certificate of Coverage for use with its commercial enrollees. Exhibit B is a copy of The Wellness Plan's Medicaid Certificate of Coverage for use with its Medicaid enrollees. Each represents a form of health maintenance contract issued by The Wellness Plan. See, e.g., Exhibit A, Article I (Definition of Certificate of Coverage).

[2] An HMO's "insureds" are referred to as "enrollees." MCL § 500.3501(d).

explained in detail below, in the context of HMOs, the regulatory scheme and operational practice of HMOs requires health care providers to submit claims directly to the HMO, and for the HMO to pay the health care provider directly. If this were not the case, and if providers billed HMO enrollees directly who then submitted the same claims for reimbursement to the HMO, there would be no question that the enrollees' claims would fall within Class 2.

This result should not change simply because the regulatory scheme and operational practice of HMOs requires providers to submit claims directly to the HMO, rather than requiring the HMO to bill the enrollee and the enrollee to submit the same claim to the HMO. As third party claimants seeking payment of benefits under health maintenance contracts issued by The Wellness Plan, The Wellness Plan Providers fall within the scope of claimants contemplated by Class 2.

2. HMO Provider Claims Should Be Afforded The Same Treatment As Claims of Insureds Under Traditional Indemnity Insurance

Chapter 81, including Section 8142, applies not only to HMOs, but to all insurers. MCL § 500.8102. It is important to understand, therefore, that there are significant differences between the manner in which HMOs and traditional indemnity insurers operate which must be considered to apply Section 8142 consistently.

In accordance with applicable law, The Wellness Plan agrees, pursuant to its health maintenance contracts, to deliver health care services to its enrollees through employees and contracted affiliated providers and to be financially responsible for the costs of those services. See MCL §§ 500.3501(f), 500.3529(2); 42 CFR § 438.206; Exhibit A, Article VI; Exhibit B, Article IV. One of the hallmarks of HMO coverage is the existence of a

network of health care providers that are affiliated with the HMO, and the requirement that enrollees seek health care services only from providers affiliated with the HMO. See e.g., Exhibit A, Section VIII B(4) (excluding coverage for unauthorized services, other than emergency services, not received from an affiliated provider). In contrast, under traditional indemnity coverage the insurer does not have affiliated provider relationships and the insured is free to choose any health care provider when he or she requires health care services that are covered under the insurance policy.

Under the HMO Act, the health care services which The Wellness Plan must cover under its health maintenance contracts must include "basic health services." MCL § 500.3519(3). The term "basic health services" includes hospital services, such as those provided by The Wellness Plan Providers. MCL § 500.3501(b). Thus, the "losses" or "benefits" covered by The Wellness Plan, under its health maintenance contracts are the medical expense payments made in connection with delivering the covered health care services specified in its health maintenance contracts, including hospital services. Exhibit A, Article VI, Section B; Exhibit B, Article IV, Section A.8 and A.14.

In this regard, HMOs and traditional indemnity health insurers are similar since both agree to be financially responsible for the cost of health care services covered under their policies/health maintenance contracts. Moreover, both receive and pay claims for covered health services rendered by health care providers although, as explained below, in the case of the traditional indemnity health insurer claims are received from the insured, while in the case of the HMO, claims are received directly from health care providers.

HMO providers, such as the Wellness Plan Providers, that render health care services to an enrollee are prohibited from billing the enrollee for those services to the extent they are covered by the health maintenance contract. See MCL §§ 500.3529(3); 400.111b(14). In fact, this Court specifically acknowledged and reiterated the principle that health care providers cannot bill HMO enrollees in its Order Placing The Wellness Plan into Rehabilitation, Approving the Appointment of a Special Deputy Rehabilitator, and Providing Injunctive Relief dated July 1, 2003. In Section 18 of that Order, this Court specifically enjoined all contracted and non-contracted health care service providers from billing Wellness Plan members for health care services rendered to them.

Likewise, under Medicaid rules, providers such as the Wellness Plan providers are required to accept payment from Medicaid health plans, such as The Wellness Plan as payment in full (with the exception of copayments or services not covered under the health maintenance contract). For example, the Medicaid Provider Manual states "Providers must not seek nor accept additional or supplemental payment from the beneficiary, the family, or representative in addition to the amount paid by Medicaid, even when a beneficiary has signed an agreement to do so. This policy also applies to payments made by [Medicaid Health Plans]." Medicaid Provider Manual, General Information for Providers, Section 12, p. 24 (available at http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html). See also, State of Michigan Qualified Health Plan Contract, Section II-M6(f) attached as Exhibit C (Requiring that the Medicaid HMO's provider contracts "prohibit the provider from seeking payment from the Enrollee for any Covered Services provided to the Enrollee

within the terms of the Contract and requir[ing] the provider to look solely to the [Medicaid HMO] for compensation for services rendered.).

Instead, the HMO provider submits claims for covered health care services directly to the HMO, and the HMO processes the claim and is responsible for making payment directly to the provider. See MCL § 500.2006(7)-(14) and 400.111i;[3] See also 42 CFR § 438.106 (Medicaid HMO is responsible for ensuring enrollee is not liable for covered services), and State of Michigan Qualified Health Plan Contract, Section II-N attached as Exhibit D (Requiring the Medicaid HMO to "make timely payments to all providers for Covered Services rendered to Enrollees."). In fact, except in very limited circumstances, an HMO is prohibited from making any payment to an enrollee and, therefore, must pay the provider directly for covered health services. See MCL § 500.3517(1).[4]

Consistent with the regulatory and operational framework described above, The Wellness Plan's health maintenance contracts contemplate that enrollees are not expected to make payment for covered health care services, and that The Wellness Plan will pay providers directly for covered health care services rendered. See Exhibit A, Article XI, Section G ("1. No cash for damage or loss will be paid to any Member. The only exception is repayment to the Member for Emergency care (as provided for in Article VI,

[3] The cited statutory provisions are known as "prompt pay" statutes, and evidence the legislature's intent that health care providers receive timely payment in recognition of the fact that the HMO receives payment in advance, on behalf of its enrollees, for health care services the enrollees receive. To ensure prompt payment, these statutory provisions require the HMO to pay penalty interest, at the rate of 12% per year, on claims that are not timely paid. In this case, the Wellness Plan Providers were not paid timely and, in fact, payment is nearly two years overdue, entitling the Wellness Plan Providers to interest on their claims at the rate of 12% per year.

[4] The only exception that permits payment to be made to the enrollee involves situations where the enrollee receives emergency care, or other care specifically authorized by the HMO, from a provider not affiliated with the HMO where payment is not otherwise made directly to the service provider. MCL § 500.3517(2).

Section H) authorized by TWP."); Exhibit B, Article VII, Section K ("A Member is not expected to pay for benefits provided by The Wellness Plan.").

Thus, in the ordinary course of the operation of an HMO such as The Wellness Plan, claims for medical expenses associated with covered health care services for which the HMO is responsible are submitted by providers directly to the HMO, and not to enrollees. Those claims are received and processed by the HMO, and payment is made directly to the providers by the HMO.

This regulatory and operational framework, pursuant to which providers and HMOs deal directly with one another with regard to payment issues, and providers are prohibited from billing the member, is distinct from the regulatory and operational framework for traditional indemnity insurers. Under traditional indemnity insurance coverage, the insurance policy obligates the insurer to make a payment directly to the insured, or to a permitted assignee of the insured, for costs associated with health care received. The regulatory scheme does not require the insurer to make payments directly to providers, nor does it require providers to bill the insurer directly or prohibit the provider from billing the insured.

In the context of Section 8142, there is no dispute that claims for medical expenses submitted by the insured to a traditional indemnity insurer would be designated as Class 2 claims. These insured claims would be seeking reimbursement for medical expenses paid by the insured to the health care provider based on the bills sent by the provider to the insured. As explained above, in the HMO context, providers do not submit bills to the enrollees, and, indeed, are prohibited from doing so. Instead, the provider submits claims directly to the HMO, and deals directly with the HMO with

respect to claims payment issues as a result of the regulatory framework governing HMO operations. The fact that the regulatory scheme requires providers to bill the HMO directly, and the HMO to pay the provider directly, does not change the fundamental character of the claim, which is a claim for medical expenses covered under the health maintenance contract issued by the HMO. Accordingly, for purposes of Section 8142, there is no meaningful distinction between a claim for health care benefits covered under an insurance policy and submitted by an insured to a traditional indemnity health insurer (which no one disputes are Class 2 claims) and a claim for health care benefits covered under a health maintenance contract and submitted by a health care provider to an HMO which should be treated, consistent with the claims of traditional indemnity insureds, as Class 2 claims for purposes of Section 8142.

3. Designating Provider Claims as Class 2 Claims Is Consistent With the Accounting Treatment Of Such Claims Mandated by OFIS

For accounting purposes, and as required by the Office of Financial and Insurance Services ("OFIS"), health care provider claims are treated as claims for losses incurred submitted under health maintenance contracts. OFIS requires HMOs, like The Wellness Plan, to report financial information in accordance with prescribed statutory accounting rules. See Order No. 04-073-M of OFIS Commissioner regarding Financial Statements and Accounting Practices and Procedures, available at www.michigan.gov/documents/cis_ofis_hmo_book_2003_80217_7.pdf. Under these statutory accounting rules, provider claims are reported as losses incurred and payments to providers are reported as benefit payments made under the HMOs health maintenance contracts. See Id., OFIS Form FIS-O320, which requires the reporting of hospital

services as "payouts" of HMO benefits, and OFIS Form FIS-0322 requiring the reporting of health care provider claims paid as "direct losses paid."[5]

Consistent with the reporting obligations specified by OFIS, The Wellness Plan reports health care provider claims as "losses incurred." See The Wellness Plan Health Annual Statement for the Year Ending December 31, 2004, Part 2C, attached hereto as Exhibit E. Since the Rehabilitator treats HMO payments for health care provider claims as losses incurred for accounting purposes under the Insurance Code, and, as a result, this is how HMOs such as The Wellness Plan report provider claims, provider claims similarly should be treated as "losses incurred" for purposes of Section 8142 of that same Insurance Code.

B. Claims of Malpractice Claimants

Claims of malpractice claimants against The Wellness Plan are Class 4 claims for purposes of Section 8142. Section 8142(1)(d) defines Class 4 claims to include "All claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property that are not under policies." As noted above, the "policies" issued by The Wellness Plan are its health maintenance contracts. The health maintenance contracts issued by The Wellness Plan cover health care services, not malpractice liabilities. See Exhibits A and B; MCL § 500.3501(e). Accordingly, any malpractice claimant's claim is not a claim arising under a Wellness Plan "policy" and should be designated a Class 4 claim for purposes of Section 8142.

IV. Conclusion

Consistent with the treatment of claims for health care expenses submitted to traditional indemnity health insurers and the treatment of provider claims under OFIS'

[5] FIS-0320 and FIS-0322 are attached to OFIS Commissioner Order No. 04-073-M

prescribed statutory accounting principles for HMOs, and in light of the fact that health care providers must bill the HMO directly, and the HMO pays the provider directly, health care provider claims should be treated as Class 2 claims for purposes of Section 500.8142. At the same time, claims of malpractice claimants rightfully should be designated as Class 4 claims. Accordingly, The Wellness Plan Providers respectfully request that this Court issue an order designating The Wellness Plan Provider's unpaid claims as Class 2 claims, and designating the claims of malpractice claimants as Class 4 claims, for purposes of the distribution of assets from The Wellness Plan's rehabilitation estate.

Respectfully submitted,

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